with no effect. Therapy with erythromycin, 1.5 g/d, was begun and after 2 weeks the chest infection had resolved clinically and radiologically. However, the polyarthropathy persisted and became incapacitating.

Various investigations in March revealed the following: A chest roentgenogram showed that the pneumonia had resolved. The erythrocyte sedimentation rate was still 40 mm/h. The latex test for rheumatoid factor was positive at a titre of 1:1280, and antibodies to *L. pneumophila* were detected at a titre of 1:250.

Antinuclear antibody testing showed speckled staining at a dilution of 1:40. At the beginning of April prednisolone, 30 mg/d at first, then decreasing doses, was started, as simpler measures had failed to control the arthropathy. All the patient's symptoms disappeared. She is presently taking 7.5 mg/d of prednisolone and has remained asymptomatic.

Our patient lives in a remote fishing community in western Nova Scotia; the lack of facilities precluded many of the investigations customarily performed in larger centres. However, we are continuing to investigate the source of the infection, and we are looking for other cases in the community.

Comments

I am unaware of reports of the development of inflammatory arthritis in Legionnaires' disease, or the coincident development of Legionnaires' disease and rheumatoid arthritis. Because of the difficulty we had in performing some of the more definitive tests for either disease, this association is presumptive, and, indeed, may be a coincidence.

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Liver failure in an infant

To the editor: I wish to comment on the "Diagnostic Challenge" that appeared in the July 19, 1980 issue of the Journal (123: 112–117). Drs. James L. Weber and Ernest Cutz discussed a case of liver failure in an infant. The 13-month-old child was admitted to hospital because of persistent vomiting and lethargy. During her hospital stay symptoms consistent with liver failure worsened progressively. The child died 5 days after admission. Weber and Cutz concluded that the fatal liver necrosis was a result of acetaminophen poisoning.

The heading "Diagnostic Challenge" fails to alert the reader to an important case in the literature. It is thought that children are protected from hepatocellular necrosis induced by toxic doses of acetaminophen.[1,2] This case is one of three reported in the literature in which, clinically and pathologically, acetaminophen toxicity resulted in hepatic necrosis in an infant. Consequently, the case deserved more attention in the Journal. Furthermore, the conclusion was not presented until near the end of the article. Although I recognize that the intent is to present a "diagnostic challenge" to physicians, the acetaminophen-induced death may be lost in the abstracting maze. I suggest that it could have been more appropriately featured as an article on the rare phenomenon of acetaminophen-induced hepatotoxic effects in an infant.

Weber and Cutz seem to be behind the times regarding the treatment of acetaminophen toxicity; intravenous therapy with cysteamine has been replaced by oral or intravenous therapy with acetylcysteine, which is an effective antidote provided treatment is started within 10 hours of ingestion.[3,4]

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[*A diagnostic challenge is written so that readers can work their way through to the diagnosis. However, in indexes such as "Index Medicus" the diagnosis would be listed and therefore retrievable.—Ed.*]

The periodic health examination

To the editor: In the Nov. 3, 1979 issue of the Journal (121: 1193–1254) was an article entitled "The periodic health examination", which was sponsored by the federal government. One of the acknowledged aims was to reduce the cost of health care services.

The report indicated that, because we lack evidence that early diagnosis is worth while, the examination should be cut to a minimum. Abdominal examination, rectal examination and electrocardiography should therefore be deleted from the annual examination. Of course this does not fit the facts. Nonruptured abdominal aneurysms are most often diagnosed during routine examinations. Baird and colleagues' reported a mortality of 50% for patients with ruptured abdominal aneurysms, but only 1% to 2% for those with aneurysms repaired electively.

As for rectal examination Klein[2] has stated that "screening for asymptomatic patients with potentially curable prostatic carcinoma relies almost exclusively upon the digital rectal examination. A report from one cancer-screening program shows that treatment of 'early' tumors found by routine digital rectal examination results in nearly perfect survival rates."

For nonpregnant women up to age 74 years the task force recommended a "health protection package" consisting of an examination of the mouth, breasts and blood pressure every 5 years, along with an occult blood test. A few other measures are optional, and they would like a few other check-ups done during visits for other reasons (at the doctor's expense).

There are considerable data on periodic health examinations. Some physicians consider them valuable, others consider them wasteful. In 1980 an examination with adequate laboratory tests for total health care assessment cost less than $100. In 1974 the average Canadian adult